HOMEHOSPICE
Community's Heart

Social Return on Investment (SROI) Community Mentoring Program

About HOME Hospice

HOME Hospice exists to change attitudes and experiences around dying and in doing so, support communities to 'live their dying'. HOME Hospice believes that enabling ordinary people to care for their dying loved ones provides a unique opportunity to build community and meaningfully connect people.

VISION
Australian communities that embrace dying as a natural part of life

MISSION
Building communities' capacity to care for dying people at home

About the Community Mentoring Program

The Community Mentoring Program takes a community development approach to end-of-life care through a clearly defined program of support for carers who are caring for someone with a terminal-illness at home. The Community Mentoring Program is not a palliative care service but rather complements those professional services by focusing on emotional and peer support for the carer.

The Community Mentoring Program is a free home based support program that links a caregiver with a Mentor who supports them with advice, wisdom and guidance, to care for a loved one at home.

The Mentor focuses solely on the needs of the caregiver, enabling them to care with greater confidence, experience less anxiety and utilise their own personal community as a support network.

Measuring our Impact

HOME Hospice engaged Social Ventures Australia (SVA) Consulting to undertake an assessment of the Community Mentoring Program using the Social Return on Investment (SROI) methodology. SROI is an internationally recognised methodology that measures the value created for stakeholders. SROI identifies, measures and accounts for the social, environmental and economic value an activity creates from the perspective of each stakeholder.

The primary objective of the SROI analysis was to understand and value the impact the Community Mentoring Program has on stakeholders such as those living with a terminal illness, caregivers, the community around each caregiver, Community Mentors, and government. HOME Hospice was eager to engage stakeholders to understand what outcomes they experienced, intended and unintended, and how they valued those outcomes. The analysis will be used to communicate the value the Community Mentoring Program creates and as an input into HOME Hospice's strategic and operational plans.

The SROI analysis is based on the investment for the 2009 calendar year. This period captures the total investment and value created from the Community Mentoring Program in 2009. Stakeholder engagement was central to the SROI analysis with 21 in-depth interviews taking place throughout the project.

Fast Facts

Social Return on Investment Index:
For every $1 invested in the Community Mentoring Program, **$3.39** is created in social value

Investment: $324,101 (includes pro-bono contributions)

Total social value created: $1.09 million

The Community Mentoring Program creates value for all stakeholders including people living with a terminal illness, caregivers, Community Mentors, the community around each caregiver and government.

Stakeholder Outcomes

The SROI analysis first identifies the major stakeholders who experience change from the Community Mentoring Program and then aims to understand what these changes are, i.e. the outcomes, for each group. The outcomes for each major stakeholder group include:

- **People living with a terminal illness** who experience an improved quality of life living at end-of-life in a caring environment at home
- **Caregivers** who have an improved quality of life with their loved one, experience less stress and anxiety in the caring process, feel more connected to their personal community and benefit from reduced amount of travel to and from hospitals, hospices or nursing homes
- **Community Mentors** who contribute by assisting caregivers to be effective in their caring and feel more personally connected with their own communities and families
- **Community around each caregiver** who gain an increased awareness and experience of the possibilities of dying at home and an understanding of how they can help the caregiver
- **Government** who benefits from a reduction in the use of health care services as more people are cared for at home and less demand is placed on hospital, hospices, nursing homes and emergency services

> *"HOME Hospice is a most extraordinary concept for many people in our modern life but entirely natural. It's about dying at home and being cared for by family and friends, which makes every day a gift of life."*
> *Caregiver, April 2010*

Calculating Social Value

The social value generated per stakeholder group is as follows:

Stakeholders	Social Value
People living with a terminal illness	$26,990
Caregivers	$685,137
Community Mentors	$66,232
Community around each caregiver	$108,865
Government	$233,695
Staff / Board members	$13,126
Total	**$1,134,045**

Note: the total social value has a discount rate of 3% applied

Highlights

- For every $1 invested in the Community Mentoring Program, $3.39 of social value is created for the community
- The social value generated by the Community Mentoring Program is $773,900 above its total direct funding
- The key driver of social value is generated by the number of caregivers supported and the outcomes they experience

> *"The strengthening of the community aspect is what drove me into working with HOME Hospice."*
> *Community Mentor, April 2010*

Considerations

- Several outcomes were not able to be monetised or were only partially monetised due to limited data
- Conservative assumptions were used throughout the analysis
- The SROI index of 3.39:1 should be considered a low level estimate and used as a baseline only, which can be refined further with more detailed data and stakeholder consultation in the future

Contact details

T: 1800 132 229

www.homehospice.com.au

HOMEHOSPICE
Community's Heart

Social Return on Investment Report

May 2010

Prepared by:

Social Ventures Australia Consulting
Gundula Coellen
Supported by: Simon Faivel

Executive Summary

This report provides a baseline Social Return on Investment (SROI) analysis of HOME Hospice's Community Mentoring Program for the 2009 calendar year. It looks retrospectively at the outcomes that have been achieved by the Community Mentoring Program.

HOME Hospice exists to change attitudes and experiences around dying and in doing so, support communities to 'live their dying'. In Australia, fewer people are dying at home partly because of the lack of support available for those who want to care for their loved ones at home. HOME Hospice began delivering their Community Mentoring Program 28 years ago and over this time has seen that when dying is experienced as a natural event in a social context at home, people are opened to a deeper connection to themselves, each other and life.

The Community Mentoring Program is a free home based support program that links a caregiver with a Mentor who supports them with advice, wisdom and guidance, to care for a loved one at home. The Mentor focuses solely on the needs of the caregiver, enabling them to care with greater confidence, experience less anxiety and utilise their own personal community as a support network.

In order to assess the social value that the Community Mentoring Program creates, HOME Hospice engaged Social Ventures Australia (SVA) Consulting, a leading SROI practitioner in Australia, to conduct the SROI analysis. SROI is an approach to understand and manage the social, economic and environmental impacts of a project, organisation or policy. It is based on stakeholders and puts a financial value on the important impacts identified by stakeholders including those that do not have market values. The SROI methodology applied to this analysis follows the international SROI Network principles and guide.

The primary objective of this SROI analysis was to understand and value the impact the Community Mentoring Program has on stakeholders such as caregivers, their communities, and the government. HOME Hospice was eager to engage stakeholders to understand what outcomes they experienced, intended and unintended, and how they valued those outcomes. The analysis will be used as an input into HOME Hospice's strategic and operational planning.

The major stakeholders of the Community Mentoring Program include:

- **People living with a terminal illness** who experience an improved quality of life by spending their end of life in a caring environment at home.
- **Caregivers** who have an improved quality of life with their loved one, experience less stress and anxiety in the caring process, feel more connected to their personal community and benefit from reduced amount of travel to and from hospitals, hospices and nursing homes.
- **Community Mentors** who contribute by assisting caregivers to be effective carers and personally feel more connected with own communities and families.
- **Community around each caregiver** who gain an increased awareness and experience of the possibilities of dying at home and an understanding of how they can help the caregiver.
- **Government** who benefits from a reduction in the use of health care services as more people are cared for at home and less demand is placed on hospital, hospices, nursing homes and emergency services.

The SROI analysis indicated that:

The Community Mentoring Program delivered an indicative SROI of 3.39:1 in CY2009.
That is for every $1 invested, approximately $3.39 of social value is created.

For a total investment of $324,101 from all stakeholders, $1,098,001 of social value was created. The investment includes a direct investment of $223,882 (69%) from philanthropic and non-profit investors, and pro-bono time valued at $100,219 (31%) from Community Mentors and staff / Board members. The impact of the investment made by funders was tested in the sensitivity analysis by excluding the pro-bono time input of Community Mentors and staff / Board members, which resulted in an SROI ratio of 4.90:1.

The most significant outcome was that caregivers were able to better care for their loved one at home by having access to the support of a Mentor and their knowledge about end of life issues, thereby creating an indicative $685,000 in social value.

Stakeholder interviews confirmed that community support was better channelled towards the greatest need. This resulted in an indicative $109,000 of social value created for the community around each caregiver as their awareness of end of life issues increases and their support is appreciated.

Caregivers are empowered to care for their loved one at home and access other services for support. This resulted in people with a terminal illness staying in hospital less and accessing fewer emergency services, resulting in an indicative $234,000 of social value created for government. This value factors in additional government spending on income support for caregivers as well as palliative care at home.

This SROI analysis is robust and should be considered conservative. The SROI ratio stays above par (1:1) even when major assumptions are tested in the sensitivity analysis and several outcomes were not at all or only partially monetised (e.g. the multiplier effect in the community of more people caring for those with terminal illnesses at home). Conservative assumptions were used throughout the analysis for the duration of outcomes, attribution to other services or people and understanding what would have happened anyway. As such, the SROI ratio of 3.39:1 should be considered a low level estimate and used as a baseline which can be refined further with more detailed data on client outcomes and through stakeholder consultation in the future.

Recommendations

Based on the findings of the SROI analysis, the following actions are recommended:

- Use this analysis to demonstrate to government the value of the Community Mentoring Program in reducing the burden on the health care system
- Better communicate the benefits of providing a mentor to the carer by promoting the Community Mentoring Program with medical services (incl. palliative care services)
- Develop the current evaluation system by tracking the outcomes achieved and sustained by the Mentors and caregivers
- Developing a more detailed understanding of the impact that the Community Mentoring Program has on the lives of people living with a terminal illness
- Further understand the impact the program has on the wider community of the caregiver

About Social Ventures Australia (SVA)

Social Ventures Australia (SVA) invests in social change by helping increase the impact and build the sustainability of social sector participants. Our investments are focused on high potential organisations that are fostering solutions to some of the most pressing challenges facing our community. SVA provides funding and strategic support to carefully selected non-profit partners, as well as offering consulting services to the social sector more broadly, including philanthropists who are endeavouring to be more strategic in their approach to giving. As a non-profit organisation at the forefront of sector development and innovation, SVA works in collaboration with sector partners, as well as government, business, and some of Australia's leading philanthropists.

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1 Project description

1.1 Purpose of the SROI

As part of its strategic review, HOME Hospice recognised a need to understand the social value the Community Mentoring Program creates for its stakeholders as well as develop and embed a more robust evaluation framework of its activities to drive future growth and impact. HOME Hospice also acknowledged that the emphasis on non-profit organisations to report on their outcomes and impact will increase in coming years.

This report assesses the Social Return on Investment (SROI) of the Community Mentoring Program for the 2009 calendar year. It provides a brief overview of the SROI methodology, project approach, the objectives and activities of HOME Hospice's Community Mentoring Program, and the key findings and assumptions made when completing the analysis. Finally, this report includes a discussion of the SROI results and recommendations.

The objectives of this project were to apply the SROI methodology to the Community Mentoring Program to:

- Identify and engage key stakeholders
    - Understand what each stakeholder wants to change (objectives), what they contribute (inputs), what activities they do (outputs) and what changes for them (outcomes, intended or unintended) as a result of their involvement
- Value the social impact created
    - Understand the value created as a result of the changes experienced by each stakeholder group by using financial proxies to value the outcomes
- Create a baseline analysis to drive performance improvement
    - Articulate what the key drivers of social value are and identify what data HOME Hospice should gather in order to better evaluate the impact of its activities

1.2 SROI Approach

Social Return on Investment (SROI) is a framework for measuring and accounting for the broad concept of value which incorporates social, environmental and economic benefits. SROI puts a value on the amount of change (impact) that takes place as a result of the program and looks at the returns to those who contribute to creating the change. It estimates a financial value for this change and compares this value to the investment required to achieve that impact, resulting in an SROI ratio. It takes standard financial measures of economic return a step further by capturing social as well as financial value.

This analysis was completed using best practice methodology developed by the SROI Network in the UK, which was funded by the UK's Office of the Third Sector. The SROI tool was first developed by the Roberts Enterprise Development Fund in the US and is now used across the US, UK and Europe. SVA has been working with the tool and overseas SROI practitioners for over six years, customising it to the Australian context and working with non profit organisations and investors. Revised guidance and training for SROI were introduced in 2009 and SVA is using the new approach. The SROI Network has introduced a process for assuring reports and accrediting SROI practitioners. SVA have 5 SROI practitioners who have submitted reports for assurance in order to become accredited practitioners (including the author of this report).

The SROI process works by developing an understanding of the program, how it meets its objectives, and how it works with its stakeholders. Critical to the process is the development of an impact map demonstrating the impact value chain for each stakeholder group. It links a stakeholders' objectives to inputs (e.g. what has been invested), to outputs (e.g. training program delivered), through to the outcomes (e.g. increase in income through employment). It then identifies indicators of achievement of outcomes which are capable of being quantified by applying financial proxies.

The next step in the process is to estimate how much of the outcome would have happened anyway and what proportion of the outcome the program is responsible for. This is achieved by looking at four filters for assigning value:

- Attribution - who else contributed to the outcome?
- Drop off - when did the value creation stop?
- Deadweight - what would have happened anyway?
- Displacement - were others displaced to create the outcome?

The SROI principles which guide the methodology are described in Appendix 1.0.

1.3 Project Approach

The HOME Hospice Community Mentoring Program SROI evaluation was undertaken in four stages. The activities undertaken in these four stages include:

- Establish scope and identify stakeholders
  - define time scale for analysis
  - define stakeholders
- Conduct stakeholder interviews
- Complete analysis and test assumptions with working group
  - synthesise data from stakeholder interviews into an impact map
  - identify relevant indicators and financial proxies to monetise the social outcomes, where possible
  - define the investment both direct and through pro bono contributions, from HOME Hospice
  - conduct follow up interviews to verify evidence where required
  - test assumptions with SVA Consultants and HOME Hospice staff
- Write report
  - write a detailed report which describes the methodology, assumptions made, results

and recommendations

- complete a 2 page overview which summarises the SROI analysis

SVA Consulting spent approximately 20 days conducting the analysis and compiling the report. HOME Hospice staff members contributed approximately 2 days assisting in the data collection and reviewing the analysis.

2 HOME Hospice and the Community Mentoring Program

2.1 HOME Hospice Overview

HOME Hospice exists to change attitudes and experiences around dying and in doing so, support communities to 'live their dying'. HOME Hospice believes that enabling ordinary people to care for their dying loved ones provides unique opportunity to build community and meaningfully connect people. HOME Hospice provides opportunities for families and communities to come together as they care for terminally ill loved ones at home, surrounded by family and friends.

HOME Hospice began delivering its Community Mentoring Program 28 years ago through the pioneering work of Dr Helen-Anne Manion OAM and Gerard Manion. Over this time the organisation has seen that when dying is experienced as a natural event in a social context, people are opened to a deeper connection to themselves, each other and life.

In 2007, HOME Hospice implemented a new model for growth which is focused on collaboration. The organisation seeks to share both the program outcomes and learnings with the wider network of stakeholders in end-of-life care.

Historically HOME Hospice had 3 different focuses: providing mentoring to caregivers, running a helpline for caregivers and educating the wider Australian community through workshops and conferences. As part of HOME Hospice's strategic planning, the key focus is bringing the Community Mentoring Program to carers and families across Australia. The plan commits HOME Hospice to focus on specific geographic communities.

VISION

Australian communities that embrace dying as a natural part of life

MISSION

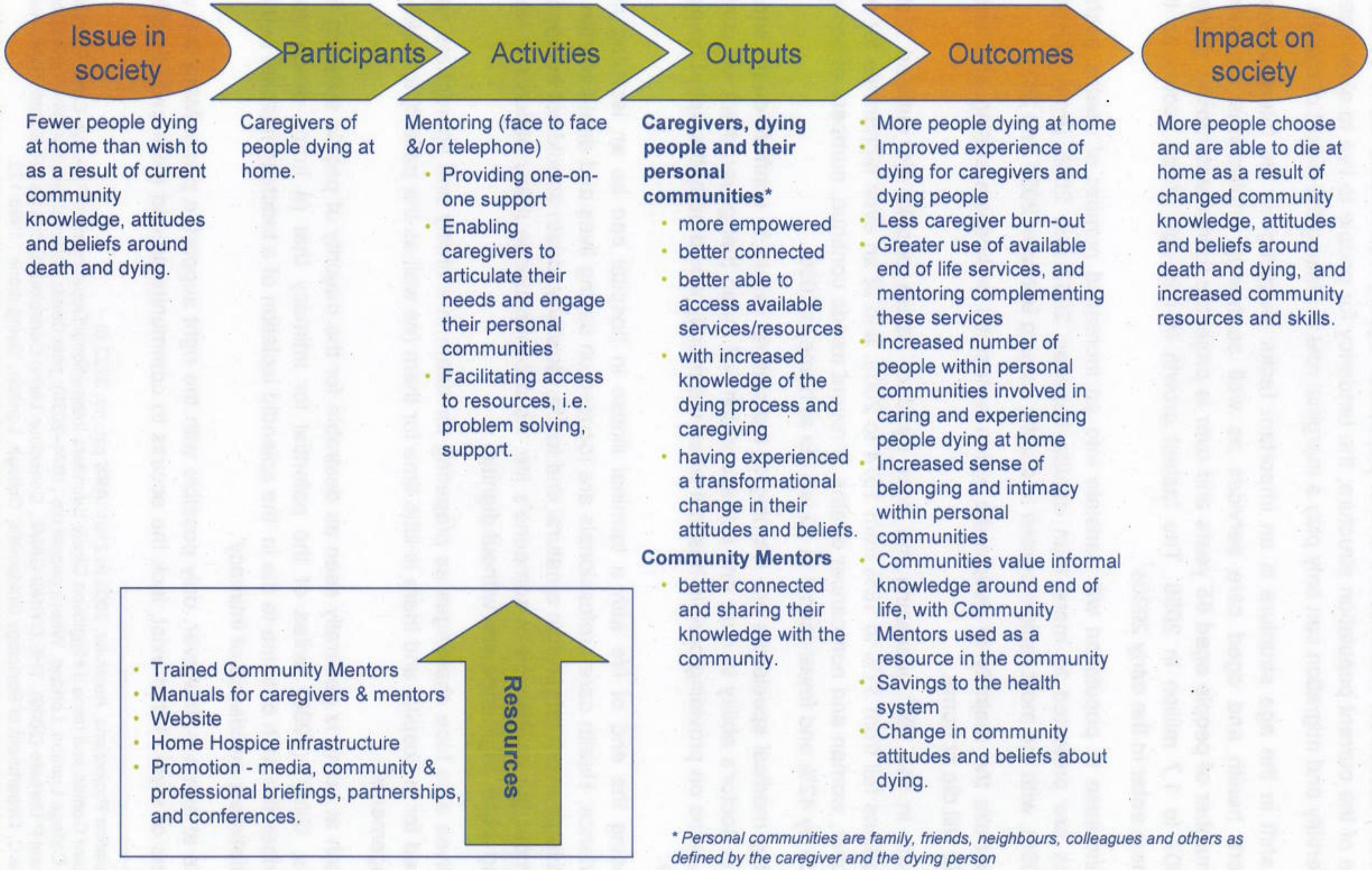
Building communities' capacity to care for dying people at home

CORE BUSINESS

HOME Hospice is a catalyst for social change around dying and death – we facilitate processes with individuals, families and communities which:

- empower people to participate in the care of those who are dying
- change attitudes and values through engagement with dying and death

2.2 HOME Hospice's Program Logic



Issue in society	Participants	Activities	Outputs	Outcomes	Impact on society
Fewer people dying at home than wish to as a result of current community knowledge, attitudes and beliefs around death and dying.	Caregivers of people dying at home.	Mentoring (face to face &/or telephone) · Providing one-on-one support · Enabling caregivers to articulate their needs and engage their personal communities · Facilitating access to resources, i.e. problem solving, support.	**Caregivers, dying people and their personal communities*** · more empowered · better connected · better able to access available services/resources · with increased knowledge of the dying process and caregiving · having experienced a transformational change in their attitudes and beliefs. **Community Mentors** · better connected and sharing their knowledge with the community.	· More people dying at home · Improved experience of dying for caregivers and dying people · Less caregiver burn-out · Greater use of available end of life services, and mentoring complementing these services · Increased number of people within personal communities involved in caring and experiencing people dying at home · Increased sense of belonging and intimacy within personal communities · Communities value informal knowledge around end of life, with Community Mentors used as a resource in the community · Savings to the health system · Change in community attitudes and beliefs about dying.	More people choose and are able to die at home as a result of changed community knowledge, attitudes and beliefs around death and dying, and increased community resources and skills.

Resources

- Trained Community Mentors
- Manuals for caregivers & mentors
- Website
- Home Hospice infrastructure
- Promotion - media, community & professional briefings, partnerships, and conferences.

** Personal communities are family, friends, neighbours, colleagues and others as defined by the caregiver and the dying person*

2.3 Issue in society

The ageing of the population is already evident in Australia and is set to continue under all projection scenarios. The reasons further population ageing is inevitable are to do with the particular shape of the current population structure; the tendency for people to live to older ages; and the fact that fertility and migration can only play a marginal role in limiting the extent of ageing.

This shift in the age structure is an important factor weighing on the future provision of income support, health and aged care services as well as having implications for economic growth. The number of people aged 85 years and over is projected to increase rapidly, going from 344,000 in 2007 to 1.7 million in 2056. The fastest growth in this age group occurs as the early baby boomers enter in the early 2030s[1].

The increase in population will translate into an increased number of deaths each year. Overall deaths are projected to more than double between 2007 and 2056 (from 137,000 in 2007 to 321,000), with the most rapid increase in deaths coming between 2027 and 2037.

In Australia the majority of people die within a hospital or hospice setting and less than 20% of people will die at home.

A study in the UK[2] assessing the past trend of where people die outlined that home death proportions fell from 31% to 18% from 1974 to 2003, and at an even higher rate for people aged 65 and over, women and non-cancer deaths. If recent trends continue, numbers of home deaths could reduce by 42% and fewer than 1 in 10 will die at home in 2030.

Leading medical specialists are warning of the cultural failure to confront death and an increasing faith in doctor's ability to cure any disease which will mean that government will continue to spend large sums on providing care in hospital when the money would be better spent on palliative care at home.

Spending the end of life with a terminal illness in hospital can be an isolating and depressing experience. Health care professionals are focused on saving lives and death is often considered as an adverse event rather than a natural end to life. However, death should not be seen as a failure of treatment but as the end of someone's life. As a consequence many patients in hospitals still die feeling alone, frightened and without dignity.

Relatives also face challenges as preparing for death in a timely and appropriate manner is rarely allowed for in hospital and there is little time for them (as well as the patient) to make the necessary arrangements[3].

A death at home is generally seen as desirable for the majority of people suffering from a terminal illness. Giley[4] (1988) writes of the potential for intimacy that (a home death) may imply, and describes the wish of some to die in 'the splendid isolation of a teaching hospital bed as a last event in a lifetime's avoidance of intimacy'.

To die at home is, however, only possible with the right support in place. Many are unaware of the options of support that exist, lack the access to community around them and are often oblivious to

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[1] Population Projections, Australia, 2006 to 2101 (ABS cat. no. 3222.0)

[2] Barbara Gomes and Irene J Higginson Cicely Saunders International/Department of Palliative Care, Policy and Rehabilitation, King's College London, London, Where people die (1974–2030): past trends, future projections and implications for care

[3] Michael P Barbato (2009), THE DYING GAME, Conscious Living Conscious Dying Centre Kiama, NSW, Australia

[4] Seale C, Department of Sociology Goldsmiths' College, London, 'Dying alone', 1995 122.

the fact that dying at home is legal.

In a recent study[5], carers were asked of the caregiver role and the care needs of their loved one. With regards to the formal support carers reported they wanted: information and advice (44%), financial assistance (38%), respite care (35%) and help with household tasks (27%). The study also reported that caregivers requested emotional support in the form of peer support as being requested more often than professional counselling.

2.4 Overview of the Community Mentoring Program

The Community Mentoring Program is a community development approach to end-of-life care and has a clearly defined program of support for carers who are caring for someone with a terminal illness. It is a program dedicated to carers of people with a terminal illness; HOME Hospice's focus is solely on the carer. The Community Mentoring Program is not a palliative care service but rather complements those professional services by focusing on emotional and peer support for the carer.

The operating principles of the program derive from a strengths-based community development approach. Community development, in the context of end-of-life, is about building the capacity of the community to care. As such, the principles of enabling and empowering ordinary people to care are the highest priority. Likewise the model is about building community, developing and strengthening the bonds between people such as family, friends, and neighbours. The program aims to generate social capital through community engagement - by helping carers to mobilise their own personal community, the "natural volunteers". This provides a context for the carer's personal community to be involved in the care of their loved one.

The program is successful because the Mentor acts as the knowledgeable friend giving advice, emotional support and guidance to the carer of a terminally ill loved one. It is in contrast to a task orientated model, such as the traditional volunteer role in palliative care, where the volunteer is primarily 'doing for' rather than 'being with'. The Mentor develops a relationship of trust and connection with the carer and as the carer and Mentor get to know each other a friendship is established. On these grounds the carer feels comfortable to call upon their Mentor for support and guidance at any time during their caring journey.

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[5] Zapart, Kenny, Hall, Servis, and Wiley (2007) Home-based palliative care in Sydney, Australia: The carer's perspective on the provision of informal care, Health and Social Care in the Community, 15(20), 97 – 107.

3 Scope & Key Assumptions

Due to the number of stakeholders involved in supporting the Community Mentoring Program, and in-line with SROI principles, a set of criteria were applied to ensure that the SROI process:

- did not over-claim the value that the Community Mentoring Program was responsible for creating
- only included value for the outcomes which were experienced by stakeholders
- was transparent about the assumptions made throughout the analysis

3.1 Rationale for the scope

Historically HOME Hospice had 3 different focuses: providing mentoring to caregivers, running a helpline for caregivers and educating the wider Australian community through workshops and conferences.

In 2009, as part of the organisation's strategic plan, the key components of the Community Mentoring Program were revisited and it was decided to place the core focus on delivering mentoring to caregivers across Australia. Therefore this SROI analysis looks at the activities of the Community Mentoring Program, excluding the helpline services and the educational element.

3.2 Period of Analysis

The time period for this SROI analysis included all the activities, investments and the value created from the Community Mentoring Program during the 2009 calendar year. There are some outcomes that were reported to have lasted for longer than one year as a result of this investment. Throughout the analysis, conservative timeframes (based on stakeholder interviews and secondary research) were used for individual outcomes.

The timeframes used for each outcome are outlined in the stakeholder impact map on page 40.

3.3 Overview of Stakeholders

After scoping the project, all stakeholders in the Community Mentoring Program were identified. The table below identifies the stakeholders and the rationale for including or excluding them from the SROI analysis.

Stakeholder Group	Included / Excluded	Rationale
People living with a terminal illness	• Included	• Major beneficiaries who are likely to experience significant outcomes if the activity is successful
Caregivers	• Included	• Major beneficiaries who are likely to experience significant outcomes if the activity is successful
Mentors	• Included	• Beneficiaries who are likely to experience significant outcomes if the activity is successful
Community around each caregiver (Family, friends, neighbours etc.)	• Included	• Beneficiaries who are likely to experience significant outcomes if the activity is successful
Government	• Included (excluded in interviewing stage)	• Beneficiaries who are likely to experience significant outcomes if the activity is successful
Funders	• Included	• Provide funding for the operation of the program
Staff/Board members	• Included	• Activity has an impact on employees beyond the direct program activities
University of Western Sydney research team	• Included	• Not a significant stakeholder of the Community Mentoring Program in CY2009. However, the research project covered similar questions about the impact of the Community Mentoring Program and some of the findings provided input into the SROI analysis
Referrers (MND association, GPs, non palliative care orgs, etc.)	• Excluded	• Increasingly important stakeholder group but not a significant stakeholder in CY2009
Palliative Care sector	• Excluded	• Future stakeholder group as HOME Hospice is planning to increasingly collaborate with Palliative care providers

Table 1: Rationale of stakeholder inclusion/exclusion

As the time available to complete the SROI analysis was limited, effort was paid to ensure adequate engagement with major stakeholders, which a priority on caregivers and mentors. A total of 21 stakeholders were engaged to understand what changes for them as a result of the Community Mentoring Program and how they would value those changes. Below is a summary of stakeholders, the size of the group and the number of stakeholders consulted:

Stakeholder Group	**Size of group (CY2009)**	**Number consulted**
People living with a terminal illness	• 75	• none
Caregivers	• 75	• 3
Community Mentors	• 50	• 4
Community around each caregiver (Family, friends, neighbours etc.)	• 14 (on average)	• 4
Government	• n/a	• n/a
Funders	• 2	• 2
Staff/Board members	• 8	• 5
University of Western Sydney research team	• 3	• 3

Table 2: Size of stakeholder group

A mixture of phone and on-site interviews were used to gather input. The majority of the community mentor interviews and staff interviews were conducted face-to-face.

Notably, engaging with the people living with terminal illnesses was not possible partly because HOME Hospice mentor's relationship is established with the carers and a direct relationship with the person being cared for is often incidental. Also, the vulnerability of terminally ill patients makes it difficult to conduct research with them.

Stakeholder Group	**Type of engagement**	**Duration**	**Location**
Caregivers	• One-on-one	• 30 mins to 1 hour each	• Phone
Community Mentors	• One-on-one	• 30 mins each	• On-site / phone
Community around each caregiver (Family, friends, neighbours etc.)	• One-on-one	• 30 mins each	• On-site
Government	• n/a	• n/a	• n/a
Funders	• One-on-one	• 30 mins each	• Phone
Staff/Board members	• One-on-one and as a group	• 1 to 2 hours each	• On-site
University of Western Sydney research team	• One-on-one	• 30 mins each	• On-site

Table 3: Type of stakeholder engagement

Stakeholders were engaged throughout the development of the SROI analysis. All stakeholders were engaged to define outcomes, indicators and proxies (see Appendix 2 for detailed information).

3.4 SROI Filters

It is important to present a realistic view of the social value created directly by the Community Mentoring Program in CY2009. In the absence of quantitative data for each filter to be applied to the outcomes, we have used conservative assumptions described below.

1. Deadweight – Deadweight is an estimation of the value that would have been created if the activities from Community Mentoring Program had not existed.

Category	Assigned Deadweight (%)
1. The outcome would not have occurred without Community Mentoring Program	0%
2. The outcome would have occurred but only to a limited extent	25%
3. The outcome would have occurred in part anyway	50%
4. The outcome would have occurred mostly anyway	75%
5. The outcome occurred anyway	100%

Table 4: Deadweight description

2. Displacement – Displacement is an assessment of how much of the outcome displaced other outcomes. As there is a significant need for dedicated services to assist those that are caring for people with a terminal illness, no displacement was applied to the outcomes identified in the SROI analysis.

3. Attribution – Attribution reflects the fact that the Community Mentoring Program is not wholly responsible for all the value creation of the outcomes described by the stakeholders.

Category	Assigned Attribution (%)
1. The outcome is completely a result of other people or organisations	100%
2. Other organisations and people have a significant role to play in generating the outcome but it was unclear as to the extent of their responsibility	50%
3. The outcome is completely a result of the Community Mentoring Program	0%

Table 5: Attribution description

4. Drop-off – Drop off is a measure which recognises that outcomes may not continue to last year on year and in future years may be less or, if the same, will more likely be influenced by other factors.

Category	Assigned Drop-off (%)
1. The outcome lasts for the whole period of time assigned to it	0%
2. The outcome drops off by 25% during the time assigned to it	25%
2. The outcome drops off by 50% during the time assigned to it	50%
3. The outcome drops off completely by the end of the time period	100%

Table 6: Drop off description

4 Description of outcomes

4.1 The Theory of Change by Stakeholder group

The theory of change is a description of the objectives, inputs, outputs and outcomes for a particular group. This section focuses on the theory of change for each stakeholder group, with an emphasis on describing the outcomes experienced by each stakeholder group through the Community Mentoring Program.

People living with a terminal illness

Objectives	Inputs	Outputs	Outcomes
• Spending end of life in a supportive environment at home	• n/a	• Being cared for by caregiver	⇩

The majority of the people living with a terminal illness were cared for at home by their primary caregiver and community around them. When caregivers and community mentors were asked what the outcomes were for their loved ones from being cared for at home, the following was reported:

- Being at home in a familiar and supportive environment improves the experience of living with a terminal illness. Daily life can continue around them and being in a home environment provides more intimacy and privacy.
- Being close to relatives often meant spending more quality time with them. Sharing a bed with their partner and eating familiar food made a big difference to their lives and improved their way of dealing with their terminal illness.
- Anecdotally, improved quality of life can sometimes even prolong life.

Caregivers

Objectives	Inputs	Outputs	Outcomes
• Access to services to provide for person who is dying • Spending more quality time with the person who is dying • Managing the loss of their loved ones better	• Time	• Support through mentoring (face to face &/or telephone): • Greater use of additional end of life services • More people associated with the personal community of the caregiver subsequently decide to care for someone dying at home	⇩

Caregivers were supported through face to face conversations, telephone and e-mail contact by a Community Mentor assigned to them.

The following outcomes through the Community Mentoring Program were experienced by caregivers:

- Improved knowledge to look after their loved one with a terminal illness at home. This knowledge was gained through their Mentor. Some caregivers reported the need to have access to a hospital bed or a night nurse and were able to receive advice from their Mentor on where to go to access additional services. This increased the caregiver's ability to focus on the caring and provided them with peace of mind.
- Improved quality of life for the caregiver with the person who is dying. Caregivers said that they were able to spend more time with them, especially during the hours of the day where the person who is dying was awake and in need to speak to somebody.

> *"At night times I sat around in my pyjamas like a young girl again chatting away with my father"*

- Reduced burn-out. Caregivers experienced a reduced sense of feeling burned-out as they were supported by their Mentors as issues arose. They also had more knowledge about who to ask for help within their personal community.
- Greater sense of legacy and leaving memory. A greater sense of leaving memory and legacy was experienced by caregiver, family members and friends as they were able to spend more time with the person who is dying. Creating lasting memories, such as photo albums, helped in the grieving process and in keeping memories alive.
- Increased sense of belonging and intimacy within personal communities resonated with many of the caregivers, especially for those who didn't have strong ties to family and community before they had the support of their Mentor. Memories were shared of good times together, such as evenings spent together chatting or cooking dinners. For some, this connectedness with their community resulted in new friendships, which would help the caregiver progress through the bereavement process.
- Reduced travel to hospital. There were significant savings in travel expenditure to visit their loved one in hospital. This was particularly important for those living in remote areas. Fuel costs and parking fees were reduced as caregivers only had to drive to hospital to take their loved one for check ups.
- Improved ability to move through the grieving process. This is confirmed by a study from the UK[6] which investigated whether carer bereavement outcomes were affected by the achievement of the patient and/or carers' preferred place of death and the relationship between the carer's satisfaction with end of life care and the bereavement outcome. It was found that if a carer received sufficient support towards for end of life care, there was a clear and significant relationship with a positive bereavement outcome. A lack of information and psychological support for the carer was associated with significantly worse initial grief, present grief and mental health. A failure to fulfil the patient and carers' wishes about where the patient died was found to lead to a negative bereavement outcome.

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[6] Palliative Medicine 2009; 23: 248-256, 'Informal carer bereavement outcome: relation to quality of end of life support and achievement of preferred place of death'

> *"A few times I thought about putting my husband up in hospital, but HOME Hospice helped me to get through those tough times and continue to provide the caring support for him at home."*

Community Mentors

Objectives	Inputs	Outputs	Outcomes
• Enabling caregivers to articulate their needs and engage their personal communities • Giving back to the community • Doing something meaningful in a close mentoring relationship	• Pro bono time (est. 2hrs per week) •Valued at $82,680	Mentoring (face to face &/or telephone): • Providing one-on-one support • Enabling caregivers to articulate their needs and engage their personal communities • Facilitating access to resources, i.e. problem solving, support	⇩

The Community Mentoring Program has a rigorous selection and training process for each Mentor to ensure they have the skills to support the caregiver they are matched with. Mentors also participate in ongoing training and have support throughout their involvement in the Community Mentoring Program.

The Mentor acts as a knowledgeable friend giving advice, emotional support and guidance to the carer of a terminally ill person who wishes to die at home. The Mentor focuses on the needs of the caregiver, giving them the strength to support themselves and their loved one throughout the journey.

Overall Mentors identified the following outcomes from participating in the Community Mentoring Program:

- Improved connectedness and sharing of knowledge with their personal community. Mentors are often approached by community members for advice on end of life issues. It adds meaning to their lives to be able to share the knowledge they have gained through their work with HOME Hospice. Mentors stated that it is a gift to volunteer and be able to help others.

> *"The strengthening of the community aspect is what drove me into working with HOME Hospice."*

- Deeper appreciation of the importance of their own family. Working with caregivers acted as a reminder on the importance of good relationships with family and communities. Many carers who approach HOME Hospice live in isolation, without any family or community support, or they may experience tension within their family to make decisions as their loved one approaches the end of their life. Some Mentors said that the work with HOME Hospice brought a better balance to their lives and they would prioritise spending more time with family and friends.

- Improved personal relationships with the caregiver and their community. A close friendship can be established at this intimate time with the caregiver. Mentors are called upon for all sorts of questions and concerns. On some occasions they are called to the house, other times they provide advice over the phone or via email. Some Mentors say that mentoring over the phone takes away the prejudices, there is no judgement involved and the caregiver is more open to share their feelings - 'You just become two people on the phone'. However, when visiting the house of the caregiver, the Mentor can often become aware of the specific needs of the caregiver. Sharing very personal issues and concerns may result in a friendship subsequent to the period of mentoring. Other mentors aim to keep mentoring at a professional level and refrain from getting too close to the caregiver and their community. This is very much dependant on the individual case.

> *"If we do our job properly and identify a person in the community of the caregiver, then we don't spend much time with them, as the key person can take over."*

- Improved focus on maintaining good health. Mentors took more care of their personal health as a result of being close to death. They recognised their own mortality and had a desire to be healthy and live longer.

> *"Death is one of THE greatest mysteries in life and when we see someone so close to approaching this great mystery it inevitably augers a review of our own mortality."*

- Fewer quality experiences with family and for personal activities. An unintended consequence of being a Mentor is that mentoring requires being responsive at any time of day, sometimes at the expense of spending quality time with friends and family or having time for personal activities.

Community around each caregiver

Objectives	Inputs	Outputs	Outcomes
• Awareness of the possibilities of dying at home • Understanding where help is needed & participation in the caring • Ability to cope with death and dying	• Time	• Supporting caregivers & person with terminal illness	

The community around the caregiver consists of family, relatives, friends and neighbours. The Mentor draws upon their assistance to provide the 'doing' so that the caregiver can focus their attention to the caring of the loved one. When asking caregivers and mentors how caring for someone at home has impacted the community, the following was reported:

- Experiencing caring for a person with a terminal illness at home changes community beliefs about dying and raises awareness of the possibilities of dying at home.

> *"Dying is a taboo subject. It's similar to 40 years ago where it was taboo for the father to be part of the birth of his child. Nowadays not being part of the birth procedure is frowned upon. The same will happen to dying at home. It will become part of our community again. But we need to work on this and we are still a long way away from it"*

- Improved understanding on how to help the caregiver. The mentor identifies the type of support needed and enables the caregiver to ask for the right help in the community. Support from community members is then channelled towards the greatest need. Mentors and caregivers have found that most communities want to help but do not know how to and either refrain from helping at all or provide too much assistance which is not needed (such as cooking too many meals) and the caregiver is incapable of rejecting it. Once people know how to help, they feel more valued as they know that their help is needed and appreciated.

> *"In the old days the community came together when someone was dying. Nowadays death is institutionalised. The community is taken out of it. Once the dying person is in hospital, the community has no more control over it."*

- Improved normalisation of dying as the person with a terminal illness is in their home environment. Relatives and friends are able to actively participate in the caring instead of simply sitting at the side of the hospital bed removed from normal life.
- Evolving fear when confronted with the intimacy and proximity of death and dying. In our society, death and dying are often treated as taboo topics. Through the support provided by the Mentor to the caregiver, the engaged community is directly confronted with death and dying, but they have a greater awareness of what is happening and how they can support the carer.

> *"HOME Hospice is a most extraordinary concept for many people in our modern life but entirely natural. It's about dying at home and being cared for by family and friends, which makes every day a gift of life."*

Government

Objectives	Inputs	Outputs	Outcomes
• Savings to the health system	• $0	• Subsidising services and income support for caregivers to provide care at home	⇩

An ageing society will place an increased burden on the health care system. The Community Mentoring Program has a positive impact by reducing the use of hospital beds by people with a terminal illness who are able to live and die at home. This results in significant cost savings to government. However, there are also costs incurred by the government to provide income support and subsidised services to assist the caregiver to support their loved one to die at home. The following outlines the positive and negative outcomes for government from the Community Mentoring Program:

- Reduced demand on the health care system as less people with a terminal illness use hospitals at the end of their lives. There is a still a small proportion of people who will use hospital services for symptom control. However due to the increased knowledge of caregivers on how to access services elsewhere, there is less demand placed on hospital services.

- Reduced costs of emergency services (ambulance call outs) due to less demand for these services. Caregivers are equipped with the knowledge of what to do in an emergency, when death is close or if death has occurred. Instead of calling the ambulance, caregivers will access other services (such as their local GP). NSW Emergency departments see almost 2.4 million people every year, of which only 20% need admission.
- Increased costs of income support for caregivers. Some caregivers need to give up their job to care for their loved ones and therefore require support from the government in the form of carer payments.
- Increased costs for people with terminal illness cared for at home. Dying at home increases the demand for Home and Community Care as more palliative services are required.

Funders

Objectives	Inputs	Outputs	Outcomes
• Contributing to enabling more caregivers to care for the dying at home	• $223,882	• Community Mentoring Program coordination & support of 50 mentors & 75 caregivers involved in '09 Community Mentoring Program	↓

During the 2009 calendar year, HOME Hospice was funded by the Cancer Council and Social Ventures Australia. The objectives of the funders are to contribute to enabling more caregivers to care for the dying at home. The outcomes for this stakeholder group are reflected in the outcomes for caregivers and community mentors.

Staff/Board Members

Objectives	Inputs	Outputs	Outcomes
• Driving the vision of HOME Hospice forward • Raising awareness of end-of-life issues & the options of dying at home • Empowering caregivers to be able to support the person who is dying	• Staff pro bono time (est. 2-3hrs per week) above paid time • Board member pro bono time (est. 6hrs per month) • Valued at $17,539	• Community Mentoring Program coordination & support of 50 mentors & 75 caregivers involved in '09 Community Mentoring Program	↓

In 2009 HOME Hospice staff and Board members were heavily involved in the operations of the organisation as there was a change in management and a period where the organisation was running without a Chief Executive Officer. During this time staff focused on raising awareness of end of life issues as well as empowering caregivers to be able to support the person who is dying by allocating the right Community Mentor. Due to their involvement at HOME Hospice, staff were actively involved in end-of-life issues in their own communities. The following outcomes were reported as the impact of working at HOME Hospice:

- Increased awareness in the community about end of life issues. All staff report being increasingly approached by their community about end of life and how caring for someone at home can be achieved. All staff members attend workshops and conferences outside of working hours on this topic. One staff member has also contributed to a book titled 'The intimacy of death & dying', which was published in 2009.
- Increased passion about end of life issues. When staff members leave HOME Hospice, they generally continue to work in end-of-life awareness and support. All staff members have reported that their experiences at HOME Hospice have had an impact on their career choices.

> *"I am having more conversations with people in my community around the importance of caring for someone at home. People come to me for advice, knowing that I work in the field and have cared for my father at home"*

University of Western Sydney (UWS) research team

Objectives	Inputs	Outputs	Outcomes
• Understanding how the experience of caring for a person dying at home can strengthen, build or transform social capital	• Time	• Ongoing development of research	⇩

The research partnership with the University of Western Sydney (UWS) began in 2007 when the Social Justice Social Change Centre (SJSC) was approached by a staff member of HOME Hospice as part of the development of a research/evaluation framework. The research was initiated on the basis that the Mentoring Program for carers is an example of a community development approach to end-of-life care in the Australian context. Social capital is generated through empowering carers with information, community building and mobilising the carers' personal community. The majority of the interviews were undertaken in 2009.

HOME Hospice is a unique model in Australia and without it UWS would not have been able to undertake such an analysis and contribute to the knowledge in end-of-life in the research community and end of life sector.

The project was funded in partnership by Cancer Council NSW and UWS. Raising awareness of end-of-life is an important part of HOME Hospice's educational activity, however the SROI analysis focused on the mentoring component, given the shift in strategic direction as outlined in section 2.1, therefore the impact of educating the wider community was not analysed as part of this study. Consequently the inputs and outcomes for the UWS research team have not been monetised.

4.2 Social Value included in the SROI Analysis

The following table shows each stakeholder group, the outcomes they experienced, the indicators used to measure the outcomes, whether data could be accessed to measure the outcome and, finally, if the outcome was included in the SROI ratio.

Outcomes per stakeholder group	Indicator	Data Access	Included in SROI Ratio
People living with terminal illness			
Improved experience of end-of-life	Being at home and able to spend more time with relatives & friends	✓	✓
	Home cooked meals	✓	✓
Caregivers			
Improved knowledge to look after person with terminal illness at home	Utilising additional services (e.g. private nurses to stay over night, home service)	✓	✓
Improved quality of life for the caregiver with the person who is dying	Additional hours spent together	✓	✓
Reduced burn-out	Savings in counselling & health care	✓	✓
Greater sense of leaving memory & legacy	Sharing memories with their family/community	✓	✓
Increased sense of belonging and intimacy within personal communities	Time spent with personal community pre and post death	✓	✓
Reduced travel to hospitals	Savings in petrol & parking	✓	✓
Improved ability to move through the grieving process (natural grieving process)	Hours of support received pre and post death	✗	✗
Community Mentors			
Improved connectedness and sharing of knowledge with their personal community	Time spent with friends/community	✓	✓
Deeper appreciation of the importance of their own family	Spending more time with the family	✓	✓
Improved personal relationships with the caregiver and their community	Continued catch ups with caregiver	✓	✓
Improved focus on maintaining good health	Going to gym	✓	✓
Reduced quality experience with family and reduced time for personal activities	Time spent	✓	✓
Community around each caregiver			
Increased awareness of the possibilities of dying at home	Number of people cared for at home	✗	✗
Increased support to the caregiver & person with terminal illness	Support is channelled towards greatest need	✓	✓
Improved normalisation of dying	Time spent with person who is dying	✗	✗
Evolving fear when confronted with the intimacy and proximity of death and dying *(leading to greater awareness)*	Avoidance of being in contact with caregiver	✗	✗
Government			
Reduced demand on health care system	Hospital not used by person with terminal illness	✓	✓

Increased costs for people with terminal illness cared for in palliative care unit	Hospital used by person with terminal illness (towards the end of life for symptoms control)	✓	✓
	Costs of emergency services (ambulance call outs, ICU)	✓	✓
	Costs of residential aged care facility	✓	✓
Increased costs of income support for caregivers	Carer payments	✓	✓
Increased costs for people with terminal illness cared for at home	Cost of Home and Community Care	✓	✓
Funders (Cancer Council & SVA)			
See outcomes for caregivers & mentors above			
Staff/Board members			
Increased awareness in the community about end of life issues	Attending workshops/contributing to a book	✓	✓
Increased passion about end of life issues	Attending conferences/developing innovative programs to involve young people in end of life caring	✓	✓
University of Western Sydney research team			
Increased knowledge in end-of-life in the research community and end of life sector	*No indicator identified*	*n/a*	*n/a*

Table 7: Stakeholder group by outcome, indicator, data access and inclusion in SROI ratio

4.3 Summary of Social Value Created

The outcomes that were able to be monetised and included in the SROI analysis are shown and then discussed below for each stakeholder group.

Outcomes per stakeholder group	Indicator	Financial Proxy	Social Value*
People living with a terminal illness			**$26,990**
Improved experience of end-of-life	Being at home and able to spend more time with relatives & friends	Volunteer rate (est. 5hrs/week)	$16,882
	Home cooked meals	Indicative price for a home cooked meal	$10,108
Caregivers			**$685,137**
Improved knowledge to look after person with terminal illness at home	Utilising additional services (e.g. private nurses to stay over night, home service)	Average cost of private home care services (est. 11 doctor home visits & private nurse service for 2 nights)	$6,917
Improved quality of life with the person who is dying	Additional hours spent together	Volunteer rate (est. 4hrs/day), an additional 12 hrs p/week compared to the time spent in hospital	$286,486
Reduced burn-out	Savings in counselling & health care	Cost of counselling (est. 5 sessions)	$33,825

Greater sense of leaving memory & legacy	Sharing memories with their family/community	Volunteer rate (time spent creating photo albums etc.) 10 hrs in total	$23,850
Increased sense of belonging and intimacy within personal communities	Time spent with personal community pre and post death	Volunteer rate (est. 1hr/week)	$124,020
Reduced travel to hospitals	Savings in petrol & parking	Cost of travel (est. avg. distance to hospital is 10 km) & parking (est. 4hrs/day) total 4 visits per week	$210,038
Community Mentors			**$66,232**
Improved connectedness and sharing of knowledge with their personal community	Time spent with friends/community	Volunteer rate (est. 1hr/fortnight)	$23 254
Deeper appreciation of the importance of their own family	Spending more time with the family	Volunteer rate (est. 1hr/week)	$46,508
Improved personal relationships with the caregiver and their community	Continued catch ups with caregiver	Cost of a coffee once every fortnight	$683
Improved focus on maintaining good health	Going to gym	Cost of gym membership	$8,190
Reduced quality experience with family and reduced time for personal activities	Time spent	Volunteer rate (est. 1hr/fortnight)	-$12,402
Community around each caregiver			**$108,865**
Increased support to the caregiver & person with terminal illness	Time spent with person who is dying	Volunteer rate (avg. 2hrs per week)	$108,865
Government			**$233,695**
Reduced demand on health care system	Hospital not used by person with terminal illness	Average in patient hospital costs per person in last year of life based on the average length of time (22.5 days)	$71,906
	Hospital used by person with terminal illness (towards the end of life for symptoms control)	Average in patient hospital cost per person (est. its reduced to two days based on stakeholder interviews)	$173,689
	Costs of emergency services (ambulance call outs, ICU)	Costs of call out (incl. avg. of 5km travel)	$50,658
Increased costs of income support for caregivers	Carer payments	Fortnightly Carer payments	-$45,116
Increased costs for people with terminal illness cared for at home	Cost of Home and Community Care	Average cost of Home and Community care payments per person (in NSW)	-$17,443
Staff/Board members			**$13,126**
Increased awareness in the community about end of life issues	Attending workshops/contributing to a book	Volunteer rate attending workshops (1/mth) & writing book (6hrs per week for 2 months)	$1,655
Increased passion about end of life issues	Attending conferences/developing innovative programs to involve young people in end of life caring	Volunteer rate (8hrs per week)	$11,472

Table 8: Monetised outcomes

** Social value calculated prior to discount rate being applied*

The outcomes that generated the most significant social value for each stakeholder group, and the rationale used for the calculations, are discussed below.

Rationale for Calculations

People living with a terminal illness

Improved experience of living with a terminal illness at the end-of-life

The improved experience of living with a terminal illness can be measured by an increase in the quality of time spent with family and friends in a supportive environment at home. This was estimated to be 5 hours a week and valued by using the volunteer rate of $15.90 per hour. There was a 50% deadweight applied to this value as the outcome could have occurred through family and friends visiting the dying person in hospital, a hospice or a nursing home.

Another indicator of this outcome is that being at home means having the opportunity to eat familiar food, such as home cooked meals. This is valued by the cost of a home cooked meal ($3.40) eaten 7 times per week. The duration of this outcome was for 4 months, which was assumed to be the average length of intense support received by the caregiver.

Overall the quality of spending time at home together rather than in an institutional environment (such as a hospital) is widely cited in research as being valuable. This analysis has attempted to value some of the benefits however, as the stakeholder was not directly engaged with due to reasons outlined in section 3.3, not all of the outcomes could be identified and valued.

Caregivers

Improved knowledge to look after person with terminal illness at home

An indicator of this outcome is that caregivers have the knowledge to access professional services they didn't know about before they had the support of their Mentor. HOME Hospice completed an evaluation in 2008 and 2009 which showed that 35% of caregivers accessed professional services. The financial proxy used to value this outcome was the average cost of private home care services, estimated as 11 home visits from doctors valued at $1,037, and a private nurse service for 2 nights valued at $560. There was a 50% attribution applied to this outcome as other family members may have contributed to this change by providing their knowledge.

Improved quality of life for the caregiver with the person who is dying

Caring for the loved one at home means spending more time with the person. The additional time spent together was valued with the volunteer rate per hour of $15.90. It was estimated that caregivers would spend an additional 12 hours per week with the person who is dying compared to the time they would spend together in hospital or hospice. There was a 50% deadweight applied to this outcome as the carer could have spend some of this time at hospital with their loved one. This financial proxy was tested in the sensitivity analysis, please refer to section 6.1.

Reduced burn-out

Secondary research shows that 82%[7] of caregivers who were supported during their loved one's dying reported that their level of anxiety was lower and they didn't have to have counselling before or after the death. The duration of this outcome was estimated to be 1 year. The financial proxy used to value this outcome was the cost of 5 counselling sessions, valued at $110 each.

Greater sense of leaving memory & legacy

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[7] HOME Hospice evaluation (2008/2009)

By spending more time with the person who is dying, family and friends can actively participate in sharing memories of the happy times they spent together. They created ways of keeping those memories alive by, for example, putting together photo albums. The supportive environment at home meant that this would not have happened without the Community Mentoring Program. This outcome was valued by estimating the amount of time spent to create an album (10 hours) and valuing this time by using the volunteer rate of $15.90 per hour. The outcome was deemed to last for 2 years due to the Community Mentoring Program.

Increased sense of belonging and intimacy within personal communities

As the community is present during the end of life stage, the caregiver spends more time with community members and feels more connected to them. Some get involved in community activities and others simply spend more time with members of their personal community. The financial proxy used was the volunteer rate of the additional hours spent together (estimated to be 1 hour per week over a two year time frame).

Reduced travel to hospitals

As caregivers were caring for their loved ones at home, they spent less time travelling to hospital, which resulted in savings in travel costs. It was estimated that caregivers would have had to drive an average distance of 10 km to the hospital 4 times per week and paid for a 4 hour parking ticket, with a total value of $8,486.

Community Mentors

Improved connectedness and sharing of knowledge with their personal community

The financial proxy used to value the indicator of spending more time sharing the knowledge with friends and the wider personal community was the volunteer rate of $15.90 per one hour every fortnight. This outcome applied to an estimate of 50% of the 75 Mentors (i.e. 38).

Deeper appreciation of the importance of their own family

The additional time spent with family was estimated to be an hour per week. As the activities with family members varied a conservative estimate of using the volunteer rate of $15.90 was applied. This outcome was reported by 50% of the Mentors (i.e. 38).

Improved personal relationships with the caregiver and their community

A small percentage of Mentors (10%) reported to have established friendships with caregivers and their community and continue to catch up on a regular basis now. Some meet up for specific activities and others meet over a coffee or two. The financial proxy used to value this outcome was the average cost of two coffees once every fortnight, given that this is one of the most common activities. Deadweight of 50% was applied to the outcome as these relationships could have been established anyway in other circumstances of the Community Mentor's life.

Improved focus on maintaining good health

More emphasis was placed on taking care of the Mentors personal health and 10% have taken up activities to improve their health such as increasing exercises. The financial proxy used to value this outcome was the average cost of a gym membership estimated at $42 a fortnight.

Reduced quality experience with family and reduced time for personal activities

The time spent mentoring meant less time was available for family and personal activities. It was estimated that 1 hour every fortnight of the two hours per week usually taken up by mentoring was at the expense of family time and/or personal activities. The financial proxy used to value this outcome was the volunteer rate.

All outcomes for Community Mentors were estimated to last for 2 years and a drop off rate of 50% was applied.

Community around each caregiver (Family, friends, neighbours etc.)

Increased support to the caregiver & person with terminal illness

Community members spend more time supporting the caregiver where help was needed the most. It was estimated that the time spent helping out took up 2 hours of the community members time per week. This feeling of being able to help and knowing that the help is appreciated was valued with the volunteer rate of $15.90.

The average size of the intermediate community of a caregiver is 14 people. 38%[8] of caregivers have accessed support from family and friends, which translates into a total of 399 community members. The size of the intermediate community of a caregiver was tested in the sensitivity analysis, please refer to section 6.1.

Government

Reduced demand on health care system

- *Hospital not used by person with terminal illness*

  43%[8] of people with a terminal illness died at home during CY2009 and reduced the costs of providing care in the hospital. The financial proxy used to value the outcome was the average inpatient hospital costs per person in the last year of life[9]. A study[10] calculated this cost to be $13,513 per person based on the average number of days spent in hospital (22.5 days) and inpatient costs that incur during the stay.

- *Hospital used by person with terminal illness (towards the end of life for symptoms control)*

  14%[8] of people with a terminal illness spent the last two days of their lives in hospital and died there. 43% of those who died at home were transferred in and out of hospital for symptoms control over the course of their illness. The financial proxy used to value this outcome was the average inpatient hospital costs per person for two days using the same research as mentioned above.

- *Costs of emergency services (ambulance call outs, ICU)*

  Less demand was placed on emergency services such as ambulance call outs. This applied to all of the 75 people living with a terminal illness. The financial proxy used for this outcome was the cost of a call out for a 5 km distance of $4,094 as set by the NSW ambulance service.

Increased costs of income support for caregivers

40% of caregivers were estimated to receive income support by government in the form of carer payments. The financial proxy assigned to this outcome was the value of the carer payment of $701 paid per fortnight. There was a 75% deadweight applied to the outcome as carer payments are still

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[8] HOME Hospice's internal evaluation (2008/2009)

[9] No proxy was available for the costs of palliative care in a hospice or nursing home

[10] Kardamanidis K., Lim K., Da Cunha C., Taylor L., Jorm L., Hospital costs of older people in New South Wales in the last year of life. MJA. Volume 187 Number 7, 1 October 2007

paid for up to 63 days in a calendar year if the person cared for is in respite care, as well as 63 days in a calendar year if the person cared for is in hospital.

Increased costs for people with terminal illness cared for at home

There were additional costs for those 43% who died at home in terms of usage of palliative care services at home. The financial proxy used to value this outcome was the average cost of Home and Community care (HACC) payments per person (in NSW) of $1,639.

Staff/Board members

Increased awareness in the community about end of life issues

All of the 3 staff members in 2009 attended workshops outside of their paid working hours and one staff member contributed to a book on the subject of end of life. To value this indicator the volunteer rate was applied to the additional hours spent outside of work.

Increased passion about end of life issues

All staff members are continuing to work in a similar field. They continue to attend conferences and one of the staff members is now involved in developing innovative programs around getting the community to participate in the end of life caring. All of this was estimated to take up 8 hours of the week and valued with the volunteer rate of $15.90.

There was a 75% deadweight applied to both outcomes accounting for the some of what would have happened anyway. A 25% drop off was applied as the duration for both outcomes was estimated to be 3 years and it is assumed that the effects of both outcomes will reduce during those 3 years. The sensitivity analysis in section 6.1 excludes the benefits to staff, however this only marginally affects the overall SROI ratio.

5 Investment Value

The following table shows the total investment in the Community Mentoring Program for the 2009 calendar year for all stakeholders.

Stakeholder	Investment
Investors funding Community Mentoring Program	$223,882
Program staff costs	$118,162
Related management/admin staff costs	$61,253
Other program related costs	$44,467
Staff/Board members – pro bono time	$17,539
Community Mentors – pro bono time	$82,680
Total investment	**$324,101**

Investors funding Community Mentoring Program

- Program staff costs cover the costs of staff apportioned to the Community Mentoring Program
- Related management and admin staff costs include Management payroll
- Other program related costs are any additional costs incurred during the 2009 calendar year

Staff/Board members

- Pro bono time was calculated based on 2.5 hours per week for staff members and 6 hours per month for Board members multiplied by the hourly volunteer rate of $15.90

Community Mentors

- Pro bono time was calculated based on 2 hours per week multiplied by the hourly volunteer rate of $15.90

6 SROI Ratio

The Community Mentoring Program delivered an indicative SROI of 3.39:1 in CY2009.

That is for every $1 invested, approximately $3.39 of social value is created.

Community Mentoring Program SROI Ratio
3.39:1

=

Net present value of benefits
$1 098 001

Net present value of investment
$324 101

To calculate the net present value (NPV), the costs and benefits incurred or generated in different time periods need to be summed. For these costs and benefits to be comparable, a process called discounting is used. A discount rate of 3.0%, which was the Australian target cash rate at 30th June 2009[11], was used for the NPV calculations.

Although no comparable SROI data could be found via the SROI Network UK for other similar services, it has been assumed that any return greater than 1:1 represents good value for stakeholders.

The social value created by the Community Mentoring Program is approximately $773,900. That is:

[Social value created by the Community Mentoring Program]

= [Net present value of benefits] – [Net present value of investments]

= $1,098,001 - $324,101

= $773,900

This value is likely to represent a lower limit of the social value generated by the Community Mentoring Program as there are a number of outcomes that were not able to be monetised or included due to limited data and research, such as:

- Improved ability to move through the grieving process
- Improved normalisation of dying as caregivers and those living with a terminal illness could continue with their lives by being at home

In addition, the unique nature of the HOME Hospice model of engaging the community of the caregiver in end of life caring could lead to a multiplier effect of more people caring for those with terminal illnesses at home. This has not been fully quantified in this SROI report, however it would be possible through the ongoing monitoring of outcomes over time.

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[11] Reserve Bank of Australia http://www.rba.gov.au/statistics/cash-rate.html

6.1 Sensitivity Analysis

The SROI ratio calculated is contingent on several assumptions and it is necessary to test the effect of changing these assumptions on the ratio. In doing so, we challenge the robustness of our assumptions to determine whether we can still be confident that the Community Mentoring Program creates value.

The assumptions that were tested in the sensitivity analysis for this report were:

1. Number of caregivers supported
2. Caregivers' time financial proxy
3. Outcomes with significant values – Caregivers hospital visits & support provided by community members
4. Funders direct investment (excl. pro bono time by Mentors, Staff/Board members)
5. Benefits to staff

The following table describes the variable, the baseline assumption, the new assumption and the resulting SROI ratio:

Variable	Baseline	New Assumption	Adjusted SROI ratio
Baseline			**3.39**
1. Number of caregivers supported	75 Caregivers	50 Caregivers	2.34
2. Caregivers' time financial proxy	$23,150 Volunteer time of spending an additional 12 hrs per week with the person who is ill ($15.90/hour)	$42,301 Difference between average salary per year and carer payments received	4.10
3. Outcomes with significant values – Caregivers hospital visits & support provided by community members	$8,486 Caregivers travel **10 km** each way to hospital & park their cars for **4hrs** $108,865 Support provided by a community of **14 members** on an average of **2 hrs** each week	$4,243 Caregivers travel **5 km** each way to hospital & park theirs cars for **2hrs** $54,432 Support provided by a community of **7 members** on an average of **2 hrs** each week	2.66
4. Funders direct investment (excl. pro bono time by Mentors, Staff/Board members)	Community Mentors $82,680 Staff/Board members $17,539	Community Mentors $0 Staff/Board members $0	4.90
5. Benefits to staff	$5,676	$0	3.35

Table 9: Sensitivity analysis

1. Number of caregivers supported

In 2009 the Community Mentoring Program consisted of 50 Community Mentors who mentored 75 caregivers. If Community Mentors only mentored 50 caregivers per year, due to longer periods of mentoring, the SROI ratio would reduce to 2.34:1. The sensitivity analysis shows that even if the Community Mentoring Program was running on a smaller scale supporting less caregivers it would still be a worthwhile investment. This scenario may also have a positive effect on the SROI ratio as the duration of outcomes for caregivers would be longer as they would have more support from their Mentor.

2. Value of caregivers' time financial proxy

The profile of the typical caregiver who approaches HOME Hospice varies. Some are already of retirement age and caring for their loved one does not have not mean they have to give up a job. However, others are at their prime working age and have to make arrangements to be able to take time off work to care for their friend or relative.

It was difficult to place a value on the quality of time spent together as for some the increased number of hours talking face to face and simply being together is invaluable. Valuing time spent together is still an area that needs to be further explored. If this time was spent undertaking a particular activity, the value of the cost of the activity could be used.

In this analysis we placed a value on the increased quality of time caregivers spend with the person who is dying by using a volunteer rate. If we value this outcome using the salary the caregiver could earn during the time of caring this leads to a much higher SROI ratio of 4.10:1. This still takes into account that 40% of caregivers receive carer payments and only the difference in the value received would be included. HOME Hospice should seek to further understand the profile of each caregiver to validate this assumption.

3. Outcomes with significant values – Caregivers hospital visits & support provided by community members

The most significant drivers of social value apart from the reduction in the demand on the health care system were the caregivers hospital visits (travel costs & parking fees) as well as the number of community members actively supporting the caregiver. We assumed that caregivers would travel 10 km each way to get to hospital and spend on average 4 hours 4 times each week there. The size of the network of each individual's community is on average 14. If we halved the kilometres travelled and time spent each visit paying for a parking meter and assumed that each individual's community network consisted of 7 instead of 14 members, the SROI ratio would decrease to 2.66:1. Once again, the robustness of the analysis is determined by the accuracy of the data collected by HOME Hospice on caregivers and how the Community Mentoring Program has changed their lives.

4. Funders direct investment (excl. pro bono time by Mentors, Staff/Board members)

The SROI analysis identified inputs other than the financial investment, such as the pro-bono time of Community Mentors and staff and Board members. It is important to monetise these inputs as the activity would not go ahead to the same extent without the pro bono time invested by these stakeholders. This ensures transparency about the full investment required to deliver the Community Mentoring Program. However, if only the direct cash investment from funders was included in the input calculation, the SROI ratio would increase to 4.90:1.

5. Benefits to staff

Staff have benefitted greatly from working at HOME Hospice in terms of professional development.

They have all reported to continue to be involved in end of life issues, by pursuing a career path in the area or by simply staying highly involved in the subject outside of work through workshops and conferences.

The SROI analysis should focus on the impact the program is trying to achieve and the stakeholders that benefit from it, hence this sensitivity analysis excludes the value to staff members and results in an SROI ratio of 3.35:1. This is only a small deviation from the original SROI ratio confirming that benefits to staff do not significantly alter the overall social value generated by the Community Mentoring Program.

7 Conclusion & Recommendations

The SROI analysis demonstrates that HOME Hospice's Community Mentoring Program creates significant social value for stakeholders.

An investment of just over $324,000 has created $773,900 in Net Present Value, resulting in an indicative SROI ratio of 3.39:1. That is, for the equivalent of every $1 invested by stakeholders in the Community Mentoring Program $3.39 is returned in social value. The SROI analysis should be considered as a baseline for the measurement of impact and value creation for HOME Hospice. It also provides insight into the type of data that HOME Hospice needs to capture to continue to prove its impact to its stakeholder groups.

Social value was created by HOME Hospice for people living with a terminal illness, their caregivers, community mentors, and those around them in their immediate community as well as government. The most significant outcome was the improved quality of life for caregivers during the time of caring. Through the support of the Community Mentor caregivers were able to focus on spending more time with the person who is dying and gently coming to terms with the inevitability of death.

The Community Mentoring Program is based on a whole of community approach and aims to identify people close to the caregiver who can support the caregiver with any additional help they may need. The Mentor's task is to channel the support towards the greatest need. This has a positive impact on the community around the caregiver as they feel valued in being able to support the caregiver in the best possible way. This social value of community support was a significant driver of the total social value creation.

Government is another core stakeholder who benefits from the Community Mentoring Program. By enabling caregivers to care for their loved ones with a terminal illness at home, less people have to rely on hospital services. This reduces the total burden placed on the health care system.

The ageing population increases the pressure on reforming the health care system. Currently many people die within a hospital often taking up beds in intensive care units which should be kept vacant for emergency cases where lives are saved. The average in patient hospital costs per person in the last year of life is $13,513[12] per person. Caring for someone with a terminal illness at home significantly reduces the demand of hospital services to those that are transferred into hospital for symptoms control for a limited amount of time.

HOME Hospice is a unique model in Australia which provides mentoring for the carer and focuses on identifying members in the community who can help in the 'doing'. The stakeholder engagement

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[12] Kardamanidis K., Lim K., Da Cunha C., Taylor L., Jorn L., Hospital costs of older people in New South Wales in the last year of life. MJA. Volume 187 Number 7, 1 October 2007

process uncovered that prior to engaging in the Program many caregivers had a lack of understanding of the value a community mentor can bring to the caregiver in the end of life stage before engaging with the program. Often the real value of a mentor was only discovered towards the end of the formal mentoring relationship. Caregivers tend to contact HOME Hospice as they reach the critical final stages of their loved ones illness, and when the caring is already taking its toll on them. This is a time where caregivers need 'hands on' assistance and have little or no time to speak to a mentor. There is potential for the mentoring to have more impact if the relationship with the caregiver is established before the final weeks of life are reached.

In conclusion, based on the findings of this SROI evaluation project, the following actions are recommended:

- Use this analysis to demonstrate to government the value of the Community Mentoring Program in reducing the burden on the health care system
- Use this analysis to develop the current evaluation system by tracking the outcomes achieved and sustained by the mentors and caregivers by:
    - Checking-in with the Mentors during the mentoring process to capture specific information on the:
        - Type and number of services accessed through the assistance of the mentor
        - Size and nature of the caregiver's support network (pre and post mentor engagement)
        - Reasons for transferring the person with a terminal illness to hospital (if required) and how long they stayed in hospital
    - Encouraging Mentors to write a summary of their case on the key challenges the caregiver faced throughout their journey of caring and how the mentor was able to assist.
- Better communicate the benefits of providing a mentor to the carer by placing more emphasis on promoting the Community Mentoring Program through increased advertising or by continuing to strengthen the partnerships with palliative care services. To date only a few palliative care services support the vision of HOME Hospice which understand the need for this kind of service to enable more people to care for their loved ones at home.
- Developing a more detailed understanding of the impact the Community Mentoring Program has on the lives of people living with a terminal illness. The focus group interview findings from the University of Western Sydney's research on 'Bringing our dying home: Creating Community at End of Life' should be analysed and incorporated into future evaluations.
- Understand the impact the Community Mentoring Program has on the wider community of the caregiver. The unique nature of the HOME Hospice model of engaging the community of the caregiver in end of life caring could lead to a multiplier effect of more people caring for those with terminal illnesses at home resulting in further savings to government in terms of less reliance on hospital services. This has not been fully quantified in this SROI report, however it would be possible through the ongoing monitoring of outcomes over time.

8 Appendix

1.0 SROI principles

The following principles guide the work conducted for an SROI analysis:

Principle	Definition
Involve stakeholders	Stakeholders should inform what gets measured and how this is measured and valued.
Understand what changes	Articulate how change is created and evaluate this through evidence gathered, recognising positive and negative changes as well as those that are intended and unintended.
Value the things that matter	Use financial proxies in order that the value of the outcomes can be recognised.
Only include what is material	Determine what information and evidence must be included in the accounts to give a true and fair picture, such that stakeholders can draw reasonable conclusions about impact.
Do not over claim	Organisations should only claim the value that they are responsible for creating.
Be transparent	Demonstrate the basis on which the analysis may be considered accurate and honest and show that it will be reported to and discussed with stakeholders.
Verify the results	Ensure appropriate independent verification of the account.

For further information on the SROI principles and methodology, please see the SROI Guide published by the SROI Network in May 2009:

http://www.sroi-uk.org

2.0 Stakeholder Engagement

Below summarises the involvement of stakeholders at each stage of the project:

Stakeholder Group	Scoping	Defining Outcomes	Defining Indicators & Financial Proxies	Verification
People living with terminal illness	✗	✗	✗	✗
Caregivers	✗	✓	✓	✓
Community Mentors	✗	✓	✓	✗
Community around the caregiver (Family, friends, neighbours etc.)	✗	✗	✗	✗
Government	✗	✗	✗	✗
Funders	✗	✗	✗	✗
Staff/Board members	✓	✓	✓	✓
University of Western Sydney research team	✗	✓	✓	✗

3.0 Questionnaire template

Objective	Interview Questions
Opening the interview	Welcome, let me tell you a little bit about who I am and what we are doing…
	Would you mind if I record this interview?
Understand their personal background	Tell us about your background?
Understand history of their involvement with the Community Mentoring Program	How did you hear about HOME Hospice
	Why did you decide to become involved with HOME Hospice?
	How are you involved?
Identify what the change has been for them as a result of HOME Hospice?	What has changed for you as a result of being involved with HOME Hospice?
	What do you do as part of the Community Mentoring Program that you didn't do before?
Identify if there are any negative changes as a result of HOME Hospice?	Have there been any negative impacts of your involvement with HOME Hospice? If so, what are they?
Determining critical success factors	How would you describe the success factors of the Community Mentoring Program?
	Which specific parts of the Community Mentoring Program are most successful in your opinion?
	What are the barriers/constraints?
	Do you have any suggestions for how to improve the Community Mentoring Program?
Understanding what each stakeholder group input into the program	What do you contribute?
	Do you make any additional contributions to HOME Hospice beyond the time you proposed to dedicate to this? (money, space, any personal contributions) Please explain and give an estimate of the financial cost of this additional contribution.
Understanding deadweight	What would have happened for you without HOME Hospice?
Understanding attribution	What other organisations or people, if any, played a role in helping you become or stay involved?
Understanding drop-off	How long do you think you will stay involved with HOME Hospice?
	How long will you continue to experience the outcomes you described?
	If the Community Mentoring Program was discontinued, how would this impact you? Would you *volunteer/go* elsewhere?
	How long do you think you will stay involved with HOME Hospice?
Closing the interview	Is there anything else that I haven't asked about the impact your involvement with HOME Hospice has had on yourself and your community around you?
	Thank you for your time, if we have any follow up questions do you mind if we contact you? If ok, what is the best way to reach you?
	Is it ok if we use some of quotes from this interview? Is there anything you are not comfortable for it to be shared in the final report of this project? Is it ok to use your responses as a case study?

4.0 Impact map

Stakeholders	Stakeholders' Objectives	Inputs		Outputs
Who changes? Who wants change?	What they want to change	What they invest (description)	What they invest (Value)	Summary of activity (quantified)
People living with terminal illness	• Spending end of life in a supportive environment at home	n/a	$0	• Being cared for by caregiver
Caregivers	• Access to services to provide for person who is dying • Spending more quality time with the person who is dying • Managing the loss of their loved ones better	Time	$0	Support through mentoring (face to face &/or telephone): • Greater use of additional end of life services • More people associated with the personal community of the caregiver subsequently decide to care for someone dying at home
Community Mentors	• Enabling caregivers to articulate their needs and engage their personal communities • Giving back to the community • Doing something meaningful in a close mentoring relationship	Pro bono time (est. 2hrs per week)	$82,680	Mentoring (face to face &/or telephone): • Providing one-on-one support • Enabling caregivers to articulate their needs and engage their personal communities • Facilitating access to resources, i.e. problem solving, support
Community around each caregiver (Family, friends, neighbours etc.)	• Awareness of the possibilities of dying at home • Understanding where help is needed & participation in the caring • Ability to cope with death and dying	Time	$0	• Supporting caregivers & person with terminal illness
Government	• Savings to the health system	n/a	$0	• Subsidising services and income support for caregivers to provide care at home
Funders (Cancer Council & SVA)	• Contributing to enabling more caregivers to care for the dying at home	Money	$223,882	• Community Mentoring Program coordination & support of 50 mentors & 75 caregivers involved in '09 Community Mentoring Program
Staff/Board members	• Driving the vision of HOME Hospice forward • Raising awareness of end-of-life issues & the options of dying at home • Empowering caregivers to be able to support the person who is dying	Staff pro bono time (est. 2-3hrs per week) Board member pro bono time (est. 6hrs per month)	$17,539	• Community Mentoring Program coordination & support of 50 mentors & 75 caregivers involved in '09 Community Mentoring Program
University of Western Sydney research team	• Understanding how the experience of caring for a person dying at home can strengthen, build or transform social capital	Time & Money	$0	• Ongoing development of research
Total			$324,101	

Impact map continued: The Outcomes

The Outcomes							
Description	Indicator	Source	Quantity	Duration (yrs)	Financial Proxy Description	Value	Source
Improved experience of living with a terminal illness	Being at home and able to spend more time with relatives & friends	Stakeholder interviews with carergivers & mentors	75	0.33	Volunteer rate (est. 5hrs/week)	$4,134	ABS average earnings estimate for volunteers
	Home cooked meals	Stakeholder interviews with carergivers & mentors	75	0.33	Indicative price for a home cooked meal	$1,238	Study by taste.com.au 'Cooking at home cheaper than takeaway'
Improved knowledge to look after person with terminal illness at home	Utilising additional services (eg private nurses to stay over night, home service)	Stakeholder interviews - 35% accessed professional services they didn't know about because of their Mentor (Evaluation '08 '09)	26	0.33	Average cost of private home care services (est. 11 doctor home visits & private nurse service for 2 nights)	$1,597	Michael Barbato 'The Dying Game'; Australian Government Department of Health and Ageing
Improved quality of life for the caregiver with the person who is dying	Additional hours spent together	Stakeholder interviews	75	0.33	Volunteer rate (est. 4hrs/day), an additional 12 hrs p/week compared to the time spent in hospital	$23,150	ABS average earnings estimate for volunteers
Reduced burn-out	Savings in counselling & health care	Secondary research - 82% of caregivers reported their level of anxiety was lessened	62	1	Cost of counselling (est. 5 sessions)	$550	Life matters psychologist (NSW) website
Greater sense of leaving memory & legacy	Sharing memories with their family/community	Stakeholder interviews	75	2	Volunteer rate (time spent creating photo albums etc.) 10 hrs in total	$159	ABS average earnings estimate for volunteers
Increased sense of belonging and intimacy within personal communities	Time spent with personal community pre and post death	Stakeholder interviews	75	2	Volunteer rate (est. 1hr/week)	$827	ABS average earnings estimate for volunteers
Reduced travel to hospitals	Savings in petrol & parking	Stakeholder interviews	75	0.33	Cost of travel (est. avg distance to hospital is 10 km) & parking (est. 4hrs/day) total of 4 visits per week	$8,486	Private Vehicle Travel Reimbursement; Metro Parking rates
Improved ability to move through the grieving process (natural grieving process)	Hours of support received pre and post death	Secondary research	75		*No financial proxy available*		
Improved connectedness and sharing of knowledge with their personal community	Time spent with friends/community	Stakeholder interviews	38	2	Volunteer rate (est. 1hr/fortnight)	$413	ABS average earnings estimate for volunteers
Deeper appreciation of the importance of their own family	Spending more time with the family	Stakeholder interviews	38	2	Volunteer rate (est. 1hr/week)	$827	ABS average earnings estimate for volunteers
Improved personal relationships with the caregiver and their community	Continued catch ups with caregiver	Stakeholder interviews	5	2	Cost of a coffee once every fortnight	$182	Stakeholder interviews
Improved focus on maintaining good health	Going to gym	Stakeholder interviews	5	2	Cost of gym membership	$1,092	Average price of a gym membership
Reduced quality experience with family and reduced time for personal activities	Time spent	Stakeholder interviews	20	2	Volunteer rate (est. 1hr/fortnight)	-$413.40	Stakeholder interviews
Increased awareness of the possibilities of dying at home	Number of people cared for at home	Interviews with Caregivers, Mentors & HH staff	1050		*No financial proxy available*		
Increased support to the caregiver & person with terminal illness	Support is channelled towards greatest need	Interviews with Caregivers, Mentors & HH staff	399	0.33	Volunteer rate (avg 2hrs per week)	$1,654	Stakeholder interviews
Improved normalisation of dying	Time spent with person who is dying	Interviews with Caregivers, Mentors & HH staff			*No financial proxy available*		
Evolving fear when confronted with the intimacy and proximity of death and dying *(leading to greater awareness)*	Avoidance of being in contact with caregiver	Interviews with Caregivers, Mentors & HH staff			*No financial proxy available*		
Reduced demand on health care system	Hospital not used by person with terminal illness	Stakeholder interviews	32	0.33	Average in patient hospital costs per person in last year of life based on the average length of time (22.5 days)	$13,513	Kardamanidis K., Lim K., Da Cunha C., Taylor L., Jorm L., Hospital costs of older people in New South Wales in the last year of life. MJA. Volume 187 Number 7, 1 October 2007
	Hospital used by person with terminal illness (towards the end of life for symptoms control)	Stakeholder interviews	43	0.33	Average in patient hospital cost per person (est. its reduced to two days based on stakeholder interviews)	$12,312	
	Costs of emergency services (ambulance call outs)	Interviews with Caregivers, Mentors & HH staff	75	0.33	Costs of call out (incl. avg of 5km travel)	$4,094	Ambulance Service of NSW
Increased costs of income support for caregivers	Carer payments	Secondary research	30	0.33	Fortnightly Carer payments	-$18,229	Centrelink
Increased costs for people with terminal illness cared for at home	Cost of Home and Community Care	Secondary research	32	0.33	Average cost of Home and Community care (HACC) payments per person (in NSW)	-$1,639	Access Economics (August 2005) "The economic value of informal care" p.39
Outcomes for caregivers & community mentors mentioned above	*See outcomes for caregivers & mentors above*						
Increased awareness in the community about end of life issues	Attending workshops/contributing to a book	Stakeholder interviews	3	3	Volunteer rate attending workshops (1/mth) & writing book (6hrs per week for 2 mths)	$954	Stakeholder interviews
Increased passion about end of life issues	Attending conferences/developing innovative programs to involve young people in end of life caring	Stakeholder interviews	3	3	Volunteer rate (8hrs per week)	$6,614	Stakeholder interviews
Increased knowledge in end-of-life in the research community and end of life sector							

Impact map continued: The Factors & Calculation

Deadweight %	Displacement %	Attribution %	Drop off %	Impact	Calculating Social Return						
What would have happened without us?	What activity did you displace?	Who else contributed to the change?	Does the outcome drop off in future years?	Outcomes times proxy less attribution, deadweight and displacement		Discount rate (%)	3.00%				
					Year 1	Year 2	Year 3	Year 4	Year 5	Total per outcome (before discounting)	Total per stakeholder (before discounting)
50%	0%	0%	0%	$16,882	$16,882	$0	$0	$0	$0	$16,882	$26,990
0%	0%	0%	0%	$10,108	$10,108	$0	$0	$0	$0	$10,108	
0%	0%	50%	0%	$6,917	$6,917	$0	$0	$0	$0	$6,917	$685,137
50%	0%	0%	0%	$286,486	$286,486	$0	$0	$0	$0	$286,486	
0%	0%	0%	0%	$33,825	$33,825	$0	$0	$0	$0	$33,825	
0%	0%	0%	0%	$11,925	$11,925	$11,925	$0	$0	$0	$23,850	
0%	0%	0%	0%	$62,010	$62,010	$62,010	$0	$0	$0	$124,020	
0%	0%	0%	0%	$210,038	$210,038	$0	$0	$0	$0	$210,038	
0%	0%	0%	0%	$0	$0	$0	$0	$0	$0	$0	
0%	0%	0%	50%	$15,503	$15,503	$7,751	$0	$0	$0	$23,254	$66,232
0%	0%	0%	50%	$31,005	$31,005	$15,503	$0	$0	$0	$46,508	
50%	0%	0%	50%	$455	$455	$228	$0	$0	$0	$683	
0%	0%	0%	50%	$5,460	$5,460	$2,730	$0	$0	$0	$8,190	
0%	0%	0%	50%	-$8,268	-$8,268	-$4,134	$0	$0	$0	-$12,402	
0%	0%	0%	0%	$0	$0	$0	$0	$0	$0	$0	$108,865
50%	0%	0%	0%	$108,865	$108,865	$0	$0	$0	$0	$108,865	
0%	0%	0%	0%	$0	$0	$0	$0	$0	$0	$0	
100%	0%	0%	0%	$0	$0	$0	$0	$0	$0	$0	
0%	0%	50%	0%	$71,906	$71,906	$0	$0	$0	$0	$71,906	$233,695
0%	0%	0%	0%	$173,689	$173,689	$0	$0	$0	$0	$173,689	
50%	0%	0%	0%	$50,658	$50,658	$0	$0	$0	$0	$50,658	
75%	0%	0%	0%	-$45,116	-$45,116	$0	$0	$0	$0	-$45,116	
0%	0%	0%	0%	-$17,443	-$17,443	$0	$0	$0	$0	-$17,443	
0%	0%	0%	0%	$0	$0	$0	$0	$0	$0	$0	$0
75%	0%	0%	25%	$716	$716	$537	$402	$0	$0	$1,655	$13,126
75%	0%	0%	25%	$4,961	$4,961	$3,721	$2,790	$0	$0	$11,472	
0%	0%	0%	0%	$0	$0	$0	$0	$0	$0	$0	$0
				$1,030,582	$1,030,582	$100,269	$3,193	$0	$0	$1,134,045	$1,134,045

Total Present Value (PV)	$1,098,001
Net Present Value (PV minus the investment)	$773,900
Social Return $ per $	$3.39